TABLE I *Cross tabulation of results of culture and direct specimen test in 395 urethral smears from men*

Results of direct specimen tests	*No (%) yielding cultures in category*:*			
	1 (n=305)	*2 (n=36)*	*3 (n=31)*	*4 (n=23)*
Category*:				
1 (n=306)	302 (99)	4 (11)	0	0
2 (n=45)	3 (1)	28 (78)	9 (29)	5 (22)
3 (n=37)	0	4 (11)	21 (68)	12 (52)
4 (n= 7)	0	0	1 (3)	6 (26)

*No of inclusion bodies seen on culture or elementary bodies in direct specimens as follows: category 1=0 (negative), category 2=<10, category 3=10-100, category 4=>100.

TABLE II *Cross tabulation of results of culture and direct specimen test in 443 cervical smears from women*

Results of direct specimen tests	*No (%) yielding cultures in category**			
	1 (n=369)	*2 (n=32)*	*3 (n=23)*	*4 (n=19)*
Category*:				
1 (n=376)	366 (99)	7 (22)	3 (13)	0
2 (n=31)	3 (1)	19 (59)	9 (39)	0
3 (n=25)	0	5 (16)	10 (44)	10 (53)
4 (n=11)	0	1 (3)	1 (4)	9 (47)

*No of inclusion bodies seen on culture or elementary bodies in direct specimens as follows: category 1=0 (negative), category 2=<10, category 3=10-100, category 4=>100.

cervix:46%, urethra:51%). In four urethral and seven cervical category 2 cultures it was not possible to find elementary bodies in the direct specimen test for the same patient (tables I and II).

These results indicate that, because of small numbers of inclusion bodies in the culture, false negative results can sometimes be expected in the direct test. The specificity of this test was high in STD clinic patients as well as in prostitutes. The sensitivity was higher in STD clinic patients than in prostitutes. Among patients with genitourinary disease, sensitivity seemed to be highest in men. Culture, however, was more sensitive if only few elementary bodies were present in the cervical and urethral exudate. False negative results were rare; most of them were found only when fewer than 10 inclusion bodies were found in the cervical (22%) and urethral (11%) smears.

Several comparative studies have shown good correlation of both diagnostic methods.[2-5] Our findings, particularly in STD clinic patients, who have more infectious elementary bodies than asymptomatic people have, confirm those studies.

Yours faithfully,
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TO THE EDITOR *Genitourinary Medicine*

Quinolones in non-gonococcal urethritis

Sir,

Shahmanesh *et al*[1] showed the efficacy of single low dose oral ciprofloxacin in treating gonococcal urethritis and stressed the failure of this regimen for treating genital infection with *Chlamydia trachomatis* and post-gonococcal urethritis.

We have treated 26 men presenting with uncomplicated non-gonococcal urethritis (NGU) with oral ciprofloxacin. The results are shown in the table. Of 13 patients treated for seven days, clinical evidence of urethritis was absent in only seven (54%) at follow up on day 14; five of six of these treatment successes reviewed on day 42 remained free from urethritis. In contrast, all 13 patients treated for 10 days had a successful clinical response at day 14; seven of 10 of these treatment successes reviewed on day 42 remained urethritis free.

Our preliminary studies suggest that ciprofloxacin achieves adequate results when given in dosages of not less than 750 mg twice daily for a minimum of 10 days. Further comparative studies are necessary to assess the

TABLE *Results of treatment with oral ciprofloxacin of 26 men with uncomplicated non-gonococcal urethritis*

Dosage of ciprofloxacin	*Duration of treatment*	*No free from urethritis/No treated*	
		Day 14	*Day 42*
500 or 750 mg twice a day	7 days	7/13	5/6
750 mg or 1 g twice a day	10 days	13/13	7/10

place of ciprofloxacin in the treatment of NGU.

Yours faithfully,
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TO THE EDITOR, *Genitourinary Medicine*

Clotrimazole pessary compared with cream in treating women with vaginal candidosis

Sir,

Recent concern about the use of oral ketoconazole for the treatment of vaginal candidosis[1 2] means that topical preparations must now be favoured. Though several highly effective topical imidazoles are available, it has become clear that the ultimate success of treatment largely depends on patient compliance and the acceptability of the preparation.[3]

Patient compliance can now be ensured by administering single doses of drugs (such as clotrimazole and isoconazole), and a recent survey suggested that when given a choice of topical treatments many patients prefer a cream to the more widely prescribed pessaries.[4] A single dose clotrimazole 10% vaginal cream in a prefilled applicator has recently been developed, which has been shown to be as effective as multiple dose regimens. (Loendersloot EW *et al*, unpublished observation.)[5] We therefore had the chance to directly compare patient acceptability and preference for cream or pessary formulations using the new single dose clotrimazole 10% cream and the established single dose clotrimazole 500 mg pessary.

We treated patients attending two genitourinary clinics with clinical signs and symptoms suggestive of vaginal candidosis. Patients entering the study were randomised into two groups. Group A administered an active pessary on night 1 and a placebo cream on night 2. Group B administered the active cream on night 1 and the placebo pessary on night 2. All patients were then asked to complete a simple questionnaire on night 3.

Of the 93 patients available for analysis, 21 preferred the pessary, 43 preferred the cream, and 29 expressed no preference. This result was significant in favour of the cream ($p<0.01$). Specifically, the cream relieved itching faster ($p<0.05$), though it was also more messy ($p<0.01$).

The preference for cream was stronger among women who had been treated previously for vaginal candidosis. This may be a particularly important consideration in obtaining maximum patient compliance in patients with recurrent vaginal candidosis who require repeated courses of treatment.

Yours faithfully,
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TO THE EDITOR, *Genitourinary Medicine*

Immunotherapeutic effect of lactobacillus vaccine, SolcoTrichovac

Sir,

In the paper by Gombosova *et al* the authors state that the immunotherapeutic effect of our lactobacillus vaccine, SolcoTrichovac, is not mediated by antibodies cross reacting with *Trichomonas vaginalis*.[1] We would like to comment on this paper as follows:

1) The conclusions of the paper are based on analysis of an unacceptably low number of postimmunisation sera (two human and two rabbit sera). Analysing these sera four to six times does not improve the statistics. Our hypothesis was based on analysis of a large number (≥ 100) of rabbit and human sera from clinical trials.[2 3]

2) The analysed postimmunisation sera showed very low titres of homologous anti-lactobacillus antibodies. From analysis of large numbers of human sera[4] we know that the seroconversion rate is high and the average homologous antibody titre clearly exceeds the level given by Gombosova *et al.* Based on our experience we claim that the sera analysed by Gombosova *et al*[1] had too low homologous antibody titres to make them suitable for further analysis, even if we do not know the exact correlation in sensitivity of the methods of analysis used by the authors and ourselves. As stated elsewhere,[3] high quality postimmunisation sera are needed to detect antibody reacting with *T vaginalis.*

The hypothesis on the mechanism of action of our lactobacillus vaccine Solco-Trichovac, as originally presented by Stojkovic,[2] might not be sufficient to explain the clinical efficacy of the vaccine in treating both trichomoniasis[5] and non-specific bacterial vaginitis.[6] We are currently investigating the immunogenic action of the vaccine at the level of B and T lymphocytes. From points 1) and 2), however, the analysis of only two rabbit and two human sera of low quality cannot entitle Gombosova *et al* to draw their conclusions, and the subsequent interferences about the possible mechanism of action are therefore of little value.

Yours faithfully,
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